

**STUDENT INFORMATION**

LEGAL NAME:		
_____	_____	_____
LAST	FIRST	MIDDLE
ENGLISH NAME (if applicable):	DATE OF BIRTH: <u>MONTH / DAY / YEAR</u>	AGE:
GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female	COUNTRY OF BIRTH:	CURRENT CITIZENSHIP:
PRIMARY LANGUAGE (specific dialect):	OTHER LANGUAGES KNOWN (specific dialect):	
	<input type="radio"/> Reads <input type="radio"/> Speaks <input type="radio"/> Writes <input type="radio"/> Reads <input type="radio"/> Speaks <input type="radio"/> Writes	
STUDENT HAS APPLIED FOR PERMANENT RESIDENCY: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE OF APPLICATION: <u>MONTH / DAY / YEAR</u>		
GRADE ENTERING:	SCHOOL YEAR APPLYING FOR:	

**PARENT INFORMATION**

FATHER'S NAME:	FATHER'S OCCUPATION:
MOTHER'S NAME:	MOTHER'S OCCUPATION:
ADDRESS IN HOME COUNTRY:	PARENTS' CONTACT NUMBERS: (Home) _____ (Cell) _____ (Email) _____
FAITH / BELIEF: <input type="checkbox"/> Christian <input type="checkbox"/> Buddhist <input type="checkbox"/> Muslim <input type="checkbox"/> None <input type="checkbox"/> Other _____	CHURCH IN HOME COUNTRY (if Christian): Name: _____ Address: _____

**ACCOMPANYING PARENT**

PARENT'S NAME:	ADDRESS WHILE IN CANADA:	PARENT'S CONTACT NUMBERS: (Home) _____ (Cell) _____ (Email) _____
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**INTERNATIONAL AGENT**

FAMILY IS USING AN INTERNATIONAL AGENT: <input type="checkbox"/> YES <input type="checkbox"/> NO	AGENT'S CONTACT NUMBERS: (Home) _____ (Cell) _____ (Email) _____
IF YES, AGENT'S NAME: _____	
AGENT'S ADDRESS:	

**MEDICAL INFORMATION**

PRIVATE MEDICAL INSURANCE POLICY # \_\_\_\_\_ OR \_\_\_\_\_ B.C. MEDICAL SERVICE PLAN CARE CARD # \_\_\_\_\_

NOTE: All students attending Hope Lutheran School must provide proof of medical coverage before starting classes.

EMERGENCY CONTACTS (List 2 people other than parents):

1) First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

2) First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

STUDENT HAS A MEDICAL CONDITION THE SCHOOL SHOULD BE AWARE OF:  YES  NO

IF YES, PLEASE PROVIDE DETAILS:

STUDENT CURRENTLY TAKING ANY MEDICATION ON A REGULAR BASIS:  YES  NO

IF YES, PLEASE PROVIDE NAME OF THE MEDICATION(S):

STUDENT WILL BE REQUIRED TO TAKE THE MEDICATION WHILE AT SCHOOL:  YES  NO*IF YES, PLEASE CONTACT THE SCHOOL FOR AN ADDITIONAL FORM.*STUDENT HAS FOOD OR DRUG ALLERGIES:  YES  NO

IF YES, PLEASE NAME ALLERGIES:

SYMPTOMS STUDENT HAS EXPERIENCED DURING AN ALLERGIC REACTION ARE:

STUDENT HAS SUFFERED AN ALLERGIC REACTION THAT HAS CAUSED THEM TO EXPERIENCE BREATHING DIFFICULTIES, DIZZINESS, FAINTING, OR SHOCK:  YES  NO

IF YES, PLEASE PROVIDE DETAILS:

STUDENT HAS REQUIRED ORAL OR INJECTABLE MEDICATION FOR AN ALLERGIC REACTION:  YES  NO*IF YES, PLEASE CONTACT THE SCHOOL FOR AN ADDITIONAL FORM.*STUDENT HAS EXPERIENCED PHYSICAL OR EMOTIONAL DISORDERS:  YES  NO

IF YES, PLEASE EXPLAIN:

DOCTOR WHILE IN CANADA: NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

DENTIST WHILE IN CANADA: NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

**EDUCATIONAL BACKGROUND**

NAME OF SCHOOL STUDENT IS CURRENTLY ATTENDING, OR ATTENDED LAST YEAR:		
SCHOOL'S ADDRESS:	SCHOOL'S CONTACT NUMBERS: (Home) _____ (Cell) _____ (Email) _____	
NAME OF PRINCIPAL:	GRADE COMPLETED:	STUDENT HAS REPEATED A GRADE(S): <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GRADE(S): _____
WHY DO YOU WANT YOUR CHILD TO ATTEND OUR SCHOOL?		
STUDENT HAS PARTICIPATED IN ADVANCED CLASSES: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, LIST CLASS(ES): _____ IF YES, LIST SCHOOL YEAR(S): _____		
STUDENT HAS ATTENDED ENGLISH LANGUAGE LEARNING CLASSES (EAL, ESL OR ELL): <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, LIST SCHOOL YEAR(S): _____ NOTE: Students will be tested for their English ability. If required, they will be placed in ELL classes until able to integrate into regular classes.		
STUDENT'S INTERESTS OR HOBBIES:		
ADDITIONAL INFORMATION THAT WOULD ASSIST THE SCHOOL IN KNOWING THIS STUDENT AS AN INDIVIDUAL:		

By signing this form I declare that I have read and understood the information contained within it, and the information I have provided is correct and accurate. In addition, I give the Principal of HLCS permission to contact all former schools, daycares &/or pre-schools my child has attended. I acknowledge that failure to knowingly fully disclose information may result in the cancellation of my child's registration at the discretion of the Principal.

\_\_\_\_\_  
Name of Parent (printed)                      Signature of Parent                      MONTH / DAY / YEAR  
Date

\_\_\_\_\_  
Name of Parent (printed)                      Signature of Parent                      MONTH / DAY / YEAR  
Date

<b>FOR OFFICE USE ONLY</b>				
General Release Form <input type="checkbox"/>	Birth Certificate <input type="checkbox"/> <small>(with official translation if applicable)</small>	Passport <input type="checkbox"/>	Current Photo <input type="checkbox"/>	Immuz. Record <input type="checkbox"/>
Report Cards/ Pre-K Report <input type="checkbox"/>	Current Study Permit <input type="checkbox"/> <small>(if applicable)</small>	Parent(s) Passport <input type="checkbox"/>	Parent(s) Visitor Permit <input type="checkbox"/> <small>(if applicable)</small>	PLR or FSP <input type="checkbox"/>
Agent Agreement <input type="checkbox"/> <small>(if applicable)</small>	Application Fee <input type="checkbox"/>	NOTES:		